



LOS ANGELES COUNTY COMMISSION ON HIV

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COMMISSION ON HIV MEETING MINUTES July 11, 2013

Approved
8/8/2013

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS PRESENT (cont.)	COMMISSION MEMBERS PRESENT (cont.)	DHSP STAFF
Michael Johnson, <i>Co-Chair</i> / Kevin James Donnelly	Sharon Holloway/Ismael Morales	Sabel Samone-Loreca/Susan Forrest	Kyle Baker
	David Kelly/Alex Castillo	Shoshanna Scholar	Angela Boger
Ricky Rosales, <i>Co-Chair</i>	AJ King	Terry Smith/Brian Mac	Max Mayañu
Alvaro Ballesteros	Lee Kochems	Harold Sterker	Carlos Vega-Matos
Joseph Cadden, MD	Mitchell Kushner	Jason Tran/Rob Lester	Paulina Zamudio
Raquel Cataldo	Brad Land	Monique Tula	
Fredy Ceja/Jose Munoz	Patsy Lawson/Miguel Palacios	Terrell Winder	
Michelle Enfield	Ted Liso/Douglas Lantis	Richard Zaldivar	COMMISSION STAFF/ CONSULTANTS
Lilia Espinoza, PhD	Abad Lopez		
Aaron Fox	Marc McMillin/Mark Davis DDS		Dawn McClendon
Lynnea Garbutt	Victoria Ortega	COMMISSION MEMBERS ABSENT	Jane Nachazel
David Giugni	Angélica Palmeros	Suzette Flynn	Glenda Pinney
Terry Goddard	Mario Pérez	Ayanna Kiburi	James Stewart
Grissel Granados/Maria Roman	Gregory Rios/Jenny O'Malley	LaShonda Spencer MD	Craig Vincent-Jones
Joe Green/Erick Sanjurja	Juan Rivera/Rev. Alejandro Escoto	Fariba Younai DDS	Erin Ward
Anthony Gutierrez	Jill Rotenberg		Nicole Werner
PUBLIC			
Herman Avilez	Carla Bailey	Marissa Begay	Adam Butler
Francisco Cabas	Jury Candelario	Camila Crespo	Pat Crosby
Zoyla Cruz	Tracey Cumberland	Laura Diven	Tom Donohue
Whitney Engeran-Cordova	Kevin Farrell	Dahlia Ferlito	Lawrence Fernandez
Mauricio Freneo	Thelma Garcia	Jerry Gates, PhD	Amy Gutierrez, PharmD
Kimler Gutierrez	Marc Hauptert	Miki Jackson	Thelma James
Uyen Kao	Barbara Kappos	Twila Kerr	Kim Kisler
Luke Klipp	Joseph Leahy	Anna Long, PhD	Kiesha McCurtis
Paul Meza	Ron Osorio	Laura Ramos	Tania Rodriguez
Martha Ron	Milton Smith	Enrique Topete	Nadrine Vadaday
Carlo Vejallo	Jason Wise		

1. CALL TO ORDER: Mr. Johnson opened the meeting at 12:25 pm.

- A. Roll Call (Present):** Ballesteros, Cadden, Cataldo, Ceja/Munoz, Enfield, Espinoza, Garbutt, Giugni, Goddard, Granados/Roman, Green, Gutierrez, Johnson/Donnelly, Kelly/Castillo, King, Kochems, Kushner, Land, Lawson/Palacios, Liso/Lantis, Lopez, McMillin, Morales, Ortega, Pérez, Rios/O'Malley, Rivera/Escoto, Rosales, Rotenberg, Samone-Loreca/Forrest, Scholar, Smith, Sterker, Tran/Lester, Tula, Winder, Zaldivar

2. INSTALLATION OF COMMISSION MEMBERSHIP:

- A. Introduction of Commission Members:** Commissioners members introduced themselves, including three nominees who were still awaiting approval by Board Office #4 (Pat Crosby) and #3 (Dahlia Ferlito and Kimler Gutierrez). With enactment of the revised County Code, the Commission constitutes a new body with terms starting July 11, 2013.
- B. Administering the Oath of Office:** Ms. Kerr, Acting Chief, Commission Services, Executive Office of the Board of Supervisors, administered the Oath of Office for the County of Los Angeles to new/pending Commissioners and Alternates.

3. BYLAWS OF THE COMMISSION: ON HIV:

A. Bylaw Approval/Ratification:

- Mr. Vincent-Jones stated Bylaws are the governing law of the body. The County Code legally establishes the body and its basic structure while the Bylaws are the Commission's document to flesh out its structure, operations and rules.
- The prior Commission body and the Prevention Planning Committee (PPC) approved the Bylaws at their May 2, 2013 joint meeting, but the newly inaugurated Commission needs to ratify the Bylaws as its own.
- The Bylaws were released again for public comment with minor revisions to update the language with last-minutes changes that were made in the Ordinance at the June 13, 2013 joint meeting in order for the new body to ratify them at their first meeting. Primarily, the revisions fall under Article I, Section 4, Duties and Responsibilities and Article II, Members.

MOTION 1: Approve revisions and ratify the Bylaws of the Commission on HIV (*Passed by Consensus*).

B. Adoption of Policies/Procedures:

- Mr. Vincent-Jones said existing policies/procedures were not in the packet as the full set from both the PPC and the prior Commission is quite large. All will be in effect until the Operations Committee can meet to review potential revisions/amendments. Most current policies/procedures are available on the Commission website.
- Policies/procedures from the prior Commission were used for the Bylaws so they will take precedence in the case of conflict between a former Commission and a former PPC policy until the Operations Committee has a chance to reconcile them.

MOTION 2: Adopt existing policies and procedures from the Commission on HIV and the Prevention Planning Committee (PPC) and maintain them in effect until otherwise revised or amended; in the case of contradictory governing policies and procedures, those policies and procedures from the Commission on HIV – as those incorporated into the Bylaws – will take precedence until such time that those contradictions can be reconciled (*Passed by Consensus*).

4. APPROVAL OF THE MEETING AGENDA:

MOTION 3: Approve the Agenda Order for the July 11, 2013 Commission on HIV meeting (*Passed by Consensus*).

5. PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP:

- Mr. Engeran-Cordova, Senior Director, Public Health, AIDS Healthcare Foundation (AHF) said he reviewed the tape of the June 13, 2013 joint meeting at which the AHF lawsuit against the County for its contract to provide HIV medications for Healthy Way LA (HWLA) patients was discussed. AHF brought suit because it believed the County had violated its own contracting rules. He asserted that the government must adhere to such rules to ensure the community receives the best possible and cost-effective services. The prior Commission criticized the County in the past for a slow and inefficient contracting process and separated from the then Office of AIDS Programs and Policy to ensure an independent voice. He urged continuing that independent voice.
- Mr. Engeran-Cordova went on to say he was grateful for his Commission service, congratulated the body on its unification and Pat Crosby, in particular, for her nomination as the new Board Office District 4 representative.
- Ms. Jackson, AHF noted a separate lawsuit against the County pertains to retaliation. Providers can be intimidated, e.g., by audits which consume staff time and funds. She asserted that documents generated through the discovery process show audits are generally requested by departments rather than being scheduled randomly. Thus, she concluded, audits can be threatened or scheduled abusively.
- Mr. Hauptert, Executive Director, West Hollywood Library Foundation (WHLF) announced development of the Dr. Michael Gottlieb HIV/AIDS Information Center (MGHAIC) to provide free access to historical and updated educational material. MGHAIC will focus on the HIV epidemic as a transformative event in history, including the scientific/medical as well as the social/cultural local and worldwide impact of the epidemic. Information will help reduce stigma, support prevention and provide resources for PLWH. Material contributions to the library are welcome. Flyers were at the registration table.

- Milton Smith, Connect2Protect, reported the PrEP Work Group held a half-day training for over 80 agencies on PEP and PrEP on 6/24/2013. A longer training including other biomedical interventions is planned for October or November 2013.

6. **COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP:** Mr. Zaldivar called all to work collaboratively. HRSA is holding Los Angeles up as a unification role model for the country and is developing a document detailing the process.

7. **CO-CHAIRS' REPORT:** Mr. Rosales indicated that HRSA convened a call with the CDC project officer, DHSP representatives, and Commission and PPC members that discussed the Commission's unification process, obstacles and lessons learned. HRSA and CDC are developing a document for jurisdictions nationwide to use in developing their own integrated HIV planning processes. He noted that LA County is a model for integration of HIV care and prevention planning, and its successes and failures will be scrutinized from which other jurisdictions may benefit.

8. **EXECUTIVE DIRECTOR'S REPORT:**

- Mr. Vincent-Jones reported Commission Co-Chairs would be elected at the August 8, 2013 meeting. They will make committee assignments soon after. Most Commission work is done in committee and then reviewed by the Commission.
- All Commissioners must serve on one standing committee, unless they live and work outside the County as a qualification for the seat. They may serve on additional committees and other working units if they choose. Commissioners who have not yet expressed a committee interest should do so soon.
- Committees will begin meeting in September and elect their co-chairs in October. Committee co-chairs also serve on the Executive Committee, which will begin meeting in November. Other Executive Committee members are the Commission Co-Chairs, the three At-Large members and the Director, DHSP. Those members will serve as the interim Executive Committee.
- Orientation on care, prevention, STDs and committee work will begin at the August 8, 2013 meeting. Mr. Vincent-Jones emphasized even longstanding duties will differ, e.g., priorities and allocations now reflects HRSA and CDC funding. A full-day orientation will be scheduled in September to address new and old Commission processes and practices.
- Work will begin over the next month on orientation manuals for each committee summarizing their duties and responsibilities, although the practices and processes to discharge those duties and responsibilities may change given the unification. The all-day Annual Meeting will likely be in November and address the Commission work plan, including the new scope of responsibility governing STD control, prevention and treatment.

9. **CONTINUITY OF COMMISSION OPERATIONS:**

A. **Operational Budgeting/Staffing:**

- Mr. Vincent-Jones reported the current budget is approximately \$1 million from HRSA and housing grants. The traditional Fiscal Year (FY) has been March 1st to February 28th, which matches the Ryan White program year. The new FY is July 1st to June 30th. That matches the County's FY and reflects a more diverse array of funding streams.
- The current motion authorizes continued use of the current budget while the next budget is being prepared with DHSP. The budget must be submitted to the County in September 2013. It is expected to include additional funding.
- Mr. Land asked if any additional staff was planned. Mr. Vincent-Jones replied in the affirmative.

MOTION 4: Continue the FY 2012-2013 Commission operational budget as the governing budgetary authority for the Commission on HIV until such time as the Commission and/or those empowered to act on its behalf in accordance with the Bylaws are able to adjust or revise it consistent with new or different FY 2013-2014 revenue and expenditure projections (*Passed by Consensus*).

B. **Commission Meeting Schedule:**

- Mr. Vincent-Jones noted the Bylaws require a set meeting day and time for the Commission and the standing committees. Motion 5 reflects a combination of the prior Commission's meeting day on the second Thursday of the month and the PPC's time from 12:00 noon to 5:00 pm.
- Mr. King asked if the meeting needed to be five hours. Mr. Vincent-Jones replied prior Commission meetings were scheduled for four and one-half hours, and often ran longer. Adding a colloquium and many new responsibilities will realistically require longer meetings.
- Mr. Gutierrez suggested 10:00 am to 3:00 pm to avoid rush hour traffic, but Mr. Stewart noted that requires lunch which adds expense. Mr. Zaldivar preferred 12:00 noon to 5:00 pm as it allowed time to check in at one's office first.

- Mr. Land said, as a PLWH, he is often spent by noon and doubted he could maintain participation later in the day. He felt most people are fresher in the morning and preferred maintaining the prior Commission's time of 9:00 am to 1:30 pm. Mr. Green preferred morning to facilitate Consumer Caucus meetings which usually follow the Commission. Mr. Ballesteros felt mornings were better for departmental guest speakers and also keeps meetings from extending into the evening if they run late. Dr. Davis felt that also facilitated physicians and dentists returning to care for patients.

MOTION 5: Establish the regular meeting day and time of the Commission on HIV as the second Thursday of the month from 12:00 noon to 5:00 pm **(Withdrawn)**.

MOTION 5A (Ballesteros/Land): Establish the regular meeting day and time of the Commission on HIV as the second Thursday of the month from 9:00 am to 1:30 pm **(Passed: 32 Ayes; 5 Opposed; 1 Abstention)**.

- C. Committee Meeting Schedule:** Carry forward standing committee meeting times unless/until changed by the committees themselves.

MOTION 6: Extend the regular meeting days and times of the Commission's standing committees until such time and if they are shifted to alternate days and/or times by committee votes in consultation with the Executive Committee (*Executive Committee: last Monday of the month, 1:00 pm – 3:00 pm; Operations Committee: last Monday of the month, 10:00 am – 12:00 noon; Public Policy (PP) Committee: fourth Wednesday of the month, 1:00 pm – 4:00 pm; Planning, Priorities and Allocations (PP&A): fourth Tuesday of the month, 1:30 – 4:30 pm; Standards and Best Practices (SBP): first Thursday of the month, 10:00 am – 12:00 noon*) **(Passed by Consensus)**.

10. CONCLUSION OF PAST COMMISSION BUSINESS:

A. Commission Meeting Minutes:

MOTION 7: Approve the minutes from the Joint Commission/PPC meetings on May 2, 2013 and June 13, 2013, as presented **(Passed by Consensus)**.

- B. Committee Meeting Minutes:** Mr. Vincent-Jones noted committees are no longer meeting so cannot approve minutes. Presented minutes were from the Executive Committee. Minutes from other committees will be presented at a later date.

MOTION 8: Approve the remaining minutes from Commission on HIV Executive Committee meetings on October 29, 2012, January 28, 2013 and February 25, 2013, as presented **(Passed by Consensus)**.

C. FY 2014 Ryan White Part A/B Allocations:

Commissioners present stated their conflicts of interest.

- Mr. Vincent-Jones noted a memorandum in the packet detailing allocations approved by the Commission at the June 13, 2013 Joint Commission/PPC meeting. There was an error of 2% in the Linkage to Care service category due to inadvertently adding the Minority AIDS Initiative allocation to the Part A/B allocations.
- ➡ Staff will work with DHSP to develop a reference list of conflicts of interest for inclusion in the packet going forward, as has been past practice at the Commission.

MOTION 9: Approve corrections to the FY 2014 Ryan White Part A/B allocations, as presented **(Passed: 30 Ayes; 0 Opposed; 6 Abstentions)**.

11. ONGOING COMMISSION BUSINESS:

A. LIHP Update: Pharmacy Access Network:

- Dr. Gutierrez, Chief Pharmacy Officer and Ms. Valaday, Chief, Ambulatory Care Pharmacy, Department of Health Services (DHS), presented on efforts to maintain services in lieu of the recent court decision cancelling DHS' current Pharmacy Benefits Manager (PBM) contract with Ramsell.
- Issues can be reported via 24/7 phone number (800.877. HWLA) or email. There has been only one major issue for a patient relocating and transferring from ADAP to Healthy Way LA (HWLA). Pharmacies are working with community partners and a retail central fill pharmacy will open when volume is sufficient. All sites now have mail-order options.
- Antiretroviral (ARV) medication prescriptions are for 30 days, consistent with ADAP practice, and 100-day prescriptions are available for chronic conditions such as hypertension and diabetes. The HWLA formulary is the same as before.
- Prescriptions are monitored for compliance so someone not taking medications can be identified after 30 days.
- Mr. Land appreciated the mail-order option especially for those living farther from urban areas. He urged 90-day ARV prescriptions as it can take a day to fill them. He also requested a fact sheet to inform consumers.
- Dr. Gutierrez said state law requires counseling when a prescription is filled for the first time. The counselor will ask at that time if the patient would like refills mailed, but a secure, verifiable address per FedEx is required. A Post Office box is not acceptable. A prescription may be valued at \$3,000 so it is important to verify receipt at an address.

- Patients do not need to sign for receipt and may use an alternate address, e.g., one homeless patient uses a church. There are also multiple sites available, e.g., High Desert Health System and El Monte Comprehensive Health Center.
- Mr. Vega-Matos added medical transportation is available in the Antelope Valley for both medical appointments and to access medications. DHSP hopes to expand that service countywide on an as-needed basis.
- Dr. Cadden preferred 90-day prescriptions as many people must take a day off work to fill prescriptions so they may become non-compliant. Dr. Gutierrez replied compliance per CD4 count is key, but noted some people also sell medications.
- Mr. McMillin asked how problems are being quantified. Dr. Gutierrez replied DHS is working with DHSP to track all patients receiving ARVs based on Ramsell data. A monthly reminder call is in the planning stage for DHS sites.
- Mr. Donnelly urged expanding the formulary especially for pain medications. Dr. Gutierrez replied there is a process for prior authorization of medications that are not on the formulary or are lost. Many patients successfully use the process.
- Ms. Palmeros suggested dispensing medications via the patient's Medical Care Coordination (MCC) team, which could monitor for compliance and address any issues. Dr. Gutierrez liked the suggestion, but noted this process will only be in effect for six months until Medicaid Expansion under the Affordable Care Act (ACA) is implemented, so such a program might not be sustainable.
- Ms. Tula asked about non-compliance interventions. Dr. Gutierrez replied data is sent to DHSP. Mr. Vega-Matos added data is sorted by clinic and sent to the pertinent MCC team. Dr. Gutierrez clarified that real time data was available via the discontinued Ramsell contract. Medication is now billed and reimbursed via American Insurance Adjusters.
- Mr. Rosales asked about services for the undocumented and for transgender people who may use names other than those reflected on official documentation. Dr. Gutierrez replied that HWLA requires five years residency or United States citizenship. The undocumented are served through the Ryan White program which makes them ADAP-eligible. State law requires the name of the prescription label to match the name used by the prescriber regardless of gender.
- Mr. Lopez asked about six-month ADAP recertification. He was due to recertify the next week, but had not received his letter from ADAP. Mr. Vegas-Matos had just received notice that six-month recertification was delayed. Even so, he suggested anyone due for recertification who had not received a letter should check in with his/her ADAP enroller.
- ➡ Drs. Cadden and Gutierrez will collaborate on a possible process for 90-day ARV prescriptions that ensures compliance.

12. OFFICER NOMINATIONS:

A. Co-Chair Nominations:

- Mr. Stewart said the sole requirement is that one Co-Chair must be HIV+. Commissioners may nominate themselves. Nominations may be emailed to Commission staff and will remain open until the election at the August meeting.
- ➡ Messrs. Johnson and Rosales were nominated and accepted the nominations.

B. Executive Committee At-Large Nominations:

- Mr. Stewart noted there are up to three At-Large member seats. Members are also automatically on the Operations Committee. It is preferred members have at least one year of experience on one of the planning bodies. Mr. Johnson added the At-Large members offer another perspective, which sets direction for the Commission. Service also provides an opportunity to develop leadership skills to chair a committee or the Commission in future.
- Commissioners may nominate themselves. Nominations may be emailed to Commission staff and will remain open until elections at the August 8, 2013 meeting. There will be a separate election for each of the three seats.
- ➡ Ms. Holloway and Messrs. King, McMillin and Smith were nominated and accepted the nominations.

13. REFLECTIVE COMMENTARY:

- ### A. The Evolution of HIV Community Planning and its Impact on HIV Services in Los Angeles County:
- John Schunhoff, PhD, Chief Deputy, DPH was unable to attend due to jury duty. His presentation will be rescheduled.

14. HIV AND STD SERVICE DELIVERY SYSTEM ORIENTATION:

- Mr. Pérez, Director, DHSP said his presentation was to begin to provide a foundation for understanding the HIV and STD systems. He planned to emphasize the HIV side at this meeting, but other key subjects will be addressed in future meetings.
- Other key subjects are: the role of local health plans in influencing the system of care; how we drive quality in systems we support; effect of September 30, 2013 Ryan White legislation expiration and possible new iterations; the treatment cascade; the role of the corrections-based health care system; STDs and the role of school-based programs; the local HIV/STD research agenda; health consumption patterns of populations served; and impacts of Covered California and ACA.

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- Mr. Pérez went on to provide a Los Angeles County Health Care Governance Overview through an HIV care and treatment system lens. The Board of Supervisors oversees a few dozen departments with three of those overseeing one or another health issue: DHS – HWLA, HIV pharmacies and direct care; Department of Public Health (DPH) – the Ryan White Program through DHSP; Department of Mental Health (DMH) – direct and contracted mental health care.
- County health care is complemented by a network of over 170 Federally Qualified Health Centers (FQHCs) and Community Health Centers (CHCs). This is one of the largest concentrations of private community health care partners in the nation. The role of these FQHCs and CHCs cannot be ignored in the delivery of critical HIV and STD services.
- DHS supports: three major health centers – LAC+USC, Harbor-UCLA and Olive View; Rancho Los Amigos National Rehabilitation Center; two Multi-Service Ambulatory Care Centers (MACCs); six Comprehensive Health Centers, of which two provide HIV medicine; and eleven Health Centers providing minimal HIV-specific medicine. DHS manages a large private Ambulatory Care Network of mostly non-profit partners and funds a Community Partners Network with 150 sites.
- DPH includes DHSP, which is responsible for implementing Ryan White, especially Part A, the state's Part B investment and assistance in facilitating ADAP enrollment. Though not a specific mandate, DHSP has inferred coordination responsibility from local planning body mandates for fourteen Part C providers; three Part D providers; two Part F dental providers; four Part D Special Projects of National Significance (SPNS) providers; UCLA, the designated AIDS research center; and HIV and STD CDC-funded services. DHSP works to drive performance and quality via reimbursement of funded services.
- DHSP was formed from three legacy programs – HIV Epidemiology Program, Office of AIDS Programs and Policy, and the STD Program – in February 2011. Full integration of the programs is still in development.
- Overall revenue is now approximately \$100 million for FY 2012-2013, which includes funding from various grant cycles. Mr. Pérez had previously reported an anticipated \$5.1 million cut due to sequestration for FY 2013-2014 and \$3.5 for FY 2014-2015. He has since received an updated estimate of \$6.1 million for FY 2013-2014 for overall revenue of approximately \$94 million and \$5.2 for FY 2014-2015, for approximately \$89 million unless there are changes in Washington, DC.
- Planning will need to accommodate a budget cut of approximately 11% from FY 2012-2013. The County was able to plan for the 2008 budget which accommodated an approximately \$13.5 million cut from the state so should be able to do so again.
- The principles of the National HIV/AIDS Strategy, released by President Obama in 2010, strongly influence the County's work. The three main principles are: reduce infections, increase access to care and reduce HIV-related health disparities.
- The Los Angeles County Continuum of HIV Services begins with prevention efforts, especially for those at high risk of HIV. For those who do seroconvert, goals are to link, engage and retain them in care and adherent to medication, with the ultimate goal of viral suppression. All stages interconnect starting with diagnosis of the estimated 13,000 undiagnosed and the large number who fall out of care after being linked. New initiatives are addressing prevention and these issues.
- DHSP supports a broad range of projects and programs including: HIV prevention and STD control; HIV testing; STD screening and treatment support; HIV care and treatment; integrated behavioral health in primary care settings; navigation, linkage, and retention initiatives; a geographic-specific STD control effort; syndemic planning and geospatial analysis; use of surveillance data, data matching and data sharing; public health investigation and use of community embedded disease intervention specialists; biomedical interventions (PEP); integrated TLC+, PrEP, and social network testing; housing services and coordination with HOPWA; MCC; and integrated community planning.
- He called particular attention to syndemic planning which addresses how related epidemics impact each other, e.g., an HIV and a syphilis epidemic feeding off each other will worsen both epidemics over time. Other key planning approaches are the increased use of data, the important role of biomedical interventions, and the implementation of MCC.
- Los Angeles County includes 88 cities as well as unincorporated areas, approximately 10 million diverse residents and two mountain ranges. The latter can impact access, e.g., mapping STD epidemics vis-à-vis clinics reveals incongruence.
- The County is 4,060 square miles or 2.6% of California's land mass, but encompasses approximately 26% of the population and 46% of PLWH. It has different barriers than Chicago, Houston, New York City, Philadelphia, Washington, DC and San Francisco due to size and scale. All would fit concurrently inside the County so their initiatives may not translate here, e.g., San Francisco launched an initiative to pick up all HIV test results daily with a messenger on a bike.
- The total living County PLWHA is approximately 59,500, a historic high. Of these: 43,900, reported named; 1,600, reported coded; 1,200, pending cases; and an estimated 12,800 unaware. He urged inviting Dr. Douglas Frye to provide a full epidemiology presentation, but said trends are fairly good with fewer diagnoses/deaths every year since the 1990s.
- There are subpopulation variations, e.g., deaths among African-Americans are declining less quickly than deaths in other racial/ethnic groups. Such variations reflect a need to focus on health disparities.
- In an overview of epidemics: STD incidence is increasing, HIV and AIDS incidence is decreasing, HIV and AIDS prevalence is increasing, HIV testing volume is increasing, HIV viral suppression levels are increasing, HIV/STD co-infection levels persist, rates for linkage to and retention in care are improving. On disparities: African-Americans are most disproportionately

impacted; disparities persist among transgender people; gay men are disproportionately impacted; young women of color are disproportionately impacted with STDs; highest burdens of STDs are in SPAs 4 and 6 and of HIV in SPAs 4, 8, 6 and 2.

- Over 58,000 cases of STDs/HIV were reported in 2010 with: Chlamydia, 73%; gonorrhea, 16%; syphilis, 5%; HIV/AIDS, 6%. Cases increased to 62,669 in 2011 with: Chlamydia, 75.8%; gonorrhea, 15.3%; syphilis, 4.4%; HIV/AIDS, 4.5%.
- Mr. Pérez noted those in the STD world often discuss “elimination” projects for syphilis or other STDs, but expectations should be questioned. Graphs detailed male and female gonorrhea, syphilis and Chlamydia rates, 2002-2011. STD conversations often focus on rates among women and women of color, but STDs are passed between men and women so both must be addressed. Women consume more health care than men, so how to attract males and females into care, and perhaps differently, should be addressed.
- Overall, African-Americans had the highest STD rates: 8 times higher Chlamydia and gonorrhea rates than Whites; 10 times higher gonorrhea and 3 times higher Chlamydia rates than Latinos. Those aged 20-24 had: 10 times higher gonorrhea and 7 times higher Chlamydia rates than Whites; 12 times higher gonorrhea and 3 times higher Chlamydia rates than Latinos. Those aged 15-19 had: 24 times higher gonorrhea and 10 times higher Chlamydia rates than Whites; 19 times higher gonorrhea and 4 times higher Chlamydia rates than Latinos.
- Mr. Pérez compared a traditional County ART distribution map broken out by SPA with maps reflecting disease clusters regardless of SPA, supervisorial district or city boundaries. The traditional map suggests that SPA 8 is highly impacted, but mapping of actual data shows the cluster is in one specific area of the SPA. Such data impacts health delivery efficacy, e.g., distribution of public health clinics, FQHCs, CHCs and pharmacies.
- There are five clusters. The Central Cluster runs from West Hollywood to Inglewood for approximately 50 to 60 square miles and represents 46% of the County’s HIV and STD burden. There is also a North Cluster in the Palmdale and Lancaster area, but it only represents approximately 1.3% of the HIV and STD burden. Clusters can also be broken down further by zip code and address, e.g., the Central Cluster follows the 101 freeway and reflects growing concerns around the Figueroa corridor.
- In addition to cluster targeting, it is also important to address demographic concerns in planning, e.g., African-Americans constitute about 9% of the County’s population but represent 27.8% of HIV and STD cases in the Central Cluster which may create more risk. That raises questions about whether systems address African-American health care needs.
- An aggressive testing program is needed to address the estimated 12,800 undiagnosed PLWH in the county. Public health testing alone cannot meet the need. Testing also occurs in private systems such as Kaiser and United Health Plan, may be mandated by a judge in some circumstances and is offered in other public systems such as the Men’s Central Jail.
- DHSP-funded tests increased to approximately 130,000 in 2012 with new diagnoses also increasing. However, some PLWH are retested multiple times, e.g., because they hope for a different result. Such tests skew data and waste resources. DHSP verifies whether a previous test result has been reported and is working to change provider, counselor and consumer behavior to ensure consumers are asked if they have been tested before and, if so, why they seek another test. Results from different sites are evaluated to assess if a particular site is testing effectively and warrants continued funding.
- Implementation of the New Directions in HIV Testing program in July 2011 resulted in an increase in tests but, more importantly, an increase in new tests and new HIV+ tests. The goal is to ensure those numbers are as close as possible.
- Linkage to, engagement in and retention in care are all key components of the continuum. The County Ryan White system has some of the best health outcome data for PLWH as compared with the private sector and other public health systems.
- There were undetectable Viral Loads (VLs) in 65% of Ryan White patients in 2009 which increased to 75% in 2010. DHSP can predict who is likely to be in care and who is likely to fall out of care. DHSP implemented MCC, following the Commission’s directives, to equip every medical site with an MCC team that works with patients to help them thrive in the care system.
- DHSP uses medical outpatient clinical performance measures to compare across clinics and review core measures such as for: labs – CD4 and VL; medication – antiretroviral therapy and prophylaxis; screening – opportunistic infections and other conditions, adherence; vaccination – hepatitis, pneumonia, influenza; counseling – HIV risk, hepatitis/alcohol, tobacco cessation; referrals – specialty consults, dental care. The goal is for the entire system to drive towards the same measures.
- Mr. Pérez stressed that it is still very difficult for DPH to paint a complete picture of the local HIV epidemic. DPH has a lot of data, but the private sector is not always compelled to advise DPH on such indicators as how many people are: in care, have suppressed VLs, have syphilis or have treated or untreated rectal gonorrhea. Gaps in such data impede system efficacy.
- It is important for planners to appreciate that people will not always choose to access available care so appropriate incentives will be needed to draw people into and help them thrive in care even after ACA implementation. For example, one group would like Covered California health plans modeled on the Kaiser small group health plan, but the Ryan White system’s HIV population is not always employed and does not always consume health care like most Kaiser patients do.

- There will also be many more HIV medical practitioners post-2014 than there are now. Over 20 years, the Ryan White system has created a system of concentrated HIV expertise at specialized HIV providers. The new financing landscape will allow more people to offer HIV medicine, but the private sector is not held to the same standards of care as is Ryan White. There is a need to explore whether there is a good capitated health plan model that drives public health improvement.
- Mr. Pérez noted Ryan White legislation expires in 45 days. The Commission has historically informed the national discussion. He felt it should be prepared to deconstruct/reconstruct the Ryan White system to meet National HIV/AIDS Strategy goals.
- Several considerations need to be addressed during the next 18 months and after 2014: HIV complexity in a managed care environment; completeness and capacity for appropriate, sensitive mental health services; and advocacy in the new healthcare plan environment for robust prevention services including biomedical interventions and sexual health services.
- Goals for the next 18 months include: strategy redesign/evolution to improve STD response, expand/evolve partner services, create jail-based program efficiencies and continue/strengthen school-based efforts with partners; system changes such as a better defined role for non-traditional partners (FQHCs, CDC and the private sector), continue progressive use of surveillance data, ACA implementation post-Ryan White/HWLA migration and resource investment refinement for the new environment; and policy issues such as performance measurement enforcement, Ryan White continuation, an expanded STD/HIV prevention/screening/treatment payer base and mandatory California opt-out HIV screening.
- Mr. Giugni asked where sequestration cuts are anticipated. Mr. Pérez replied dollar amounts are changing because of how federal departments release notices of grant awards. Notices are typically for a twelve-month period, but can be for three months with a notice for the remaining nine months sent later. DHSP is tallying these notices as they arrive. Larger cuts are in larger grants with the Ryan White Part A cut the largest. Current cuts are mostly in the 5.5% to 4.5% range.
- Ms. Roman asked about data on transgender women as it relates to funding services. Mr. Pérez said one of the successes of the HIV surveillance system is the comprehensiveness of data reporting including race/ethnicity, age and gender. STD data reporting does not yet include the same sexual orientation and gender parameters, but an effort is underway to modernize it in order to paint a complete picture of groups that are burdened by a cross-section of co-morbidities.
- Ms. Ortega noted the transgender population, while small, has a high infection rate of approximately 24%. She also urged incorporating a logic model with outcomes plus resources and activities to achieve them into the Commission work plan.
- ➡ DHSP will develop an itemized list of grant reductions for the Commission's information.

15. COMMISSION ON HIV ORIENTATION: This item was postponed until the August 8, 2013 meeting.

16. MEETING/PARLIAMENTARY ORIENTATION: This item was postponed until the August 8, 2013 meeting.

18. THE WALL LAS MEMORIAS:

A. Re-dedicating ourselves to ending HIV...

- The meeting reconvened at the Wall Las Memorias monument. Mr. Zaldivar, Executive Director, Wall Las Memorias Project and former PPC member introduced Ms. Rodriguez, Chairperson of the Board. He noted Mr. Ceja was previously on the Board and now works for Councilmember Gilbert Cedillo, whose First District includes Lincoln Park.
- Mr. Zaldivar became involved in the fight against HIV when a friend tested HIV+ 20 years ago. Especially in the Latino community, there was little conversation. There is more today, but many Latino LGBT remain at home and isolated.
- The Wall Las Memorias campaign was launched December 1, 1993. A deeply spiritual experience, support and funding came from the community, then State Senator Cedillo, then Mayor James Hahn, the California Endowment, the Episcopal Diocese of Los Angeles and many others despite opposition from a vocal few.
- The monument is designed as a Quetzalcoatl serpent, the Aztec god of culture and health with six murals, two granite walls with over 560 names inscribed to date and a meditation garden. Renovations of approximately \$150,000 in landscaping, lighting and benches will be dedicated for the 20th anniversary of the organization next year.
- Many still lack a safe place to talk about HIV, but this monument offers such a space. It provides an opening for outreach and to build community, e.g., Wall Las Memorias will meet with 13 evangelical ministers on July 13, 2013 to discuss God, religion, faith and HIV. Mothers come who have lost their sons. Partners who have lost partners.
- He urged all to set aside differences from where we grew up, to politics, to personal ambitions and egos. Instead, remember why we are all here as a community: to end AIDS. The monument provides the community an opportunity to hold a shared discussion, collectively reunite and unify our spirits, which move our passion to end AIDS.

- B. Remembering those on whose shoulders we stand...** Many came forward to remember and honor with a rose placed at the monument: parents, husbands, partners, an uncle, a mother-in-law, a sister-in-law, a brother-in-law, friends, mentors, community outreach co-workers and children.
- C. Recognizing long-standing members who are retiring from the planning process...**
- Dr. Long was honored for her 13 years of Commission service providing a calm, detailed voice of wisdom. Mr. Land praised her as a great mentor and stateswoman who helped him listen better and understand and trust his colleagues. He began with Act Up Los Angeles so found it hard to trust government, but responded to her heart for the people.
 - Dr. Long said she has seen the community face many challenges. While challenges now are different, the community is well equipped to address them. It has new tools, broad representation and a community-driven process. She encouraged people to remember they are in this fight together, to work well with and to respect each other's perspectives. At the end of the day, everything should be set aside to serve the people we all are fighting for.
 - Mr. Topete was honored for two PPC terms covering six years plus two-and-a-half more years to help with unification. He was Chair, Standards and Best Practices Committee and a Latino Task Force member. His warmth and joy will be missed. Mr. Topete said the PPC helped him grow as a person and broadened his vision of the community.
 - Mr. Engeran-Cordova was honored for his years of Commission service including Co-Chair, Public Policy Committee as it transitioned to the Joint Public Policy Committee of the Commission and PPC. He asked hard questions and pushed the Commission to take stands on conscience even when uncomfortable. Mr. Engeran-Cordova urged unity while also discussing differences openly and taking a stand as needed. Those stated differences add to and enhance the process.
 - Ms. Bailey was honored for her years of Commission service. Most recently Commission Co-Chair, she has been a strong mentor for every Commissioner and represented the Commission at the local, state and federal level. Ms. Bailey said the Commission has accomplished much, but work remains to face the challenges ahead. She pledged her support.
 - Ms. James was honored for her years on the Commission offering a unique new voice and perspective.
 - Mr. Rosales also honored in absentia key PPC members: Juli-Ann Carlos-Henderson, Trevor Daniels and Kathy Watt for their service in both this and the previous process, as well as Elizabeth Escobedo who provided essential staff support.
 - Mr. Johnson honored in absentia Anthony Braswell, former Commission Co-Chair, for critical leadership that helped the Commission reach this goal of unification. Mr. Johnson also honored Ms. McClendon, Ms. Nachazel, Ms. Pinney, Mr. Vincent-Jones and Ms. Werner for long hours of critical Commission staff support especially during this past year.

19. CONCLUDING COMMENTS:

- A. Reflections on the Past/Prospects for the Future:** There were no additional reflections.

20. ADJOURNMENT: The meeting adjourned at 4:00 pm.

- A. Roll Call (Present):** Ballesteros, Cadden, Cataldo, Ceja/Munoz, Fox, Garbutt, Giugni, Goddard, Granados/Roman, Green/Sanjuro, Gutierrez, Holloway/Morales, Johnson/Donnelly, Kelly/Castillo, King, Kochems, Kushner, Land, Lawson, Liso/Lantis, Lopez, McMillin, Ortega, Palmeros, Rios/O'Malley, Rivera/Escoto, Rosales, Rotenberg, Samone-Loreca/Forrest, Smith/Mac, Sterker, Tran/Lester, Tula, Winder, Zaldivar

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MOTION AND VOTING SUMMARY		
MOTION 1: Approve revisions and ratify the Bylaws of the Commission on HIV.	<i>Passed by Consensus</i>	MOTION PASSED
MOTION 2: Adopt existing policies and procedures from the Commission on HIV and the Prevention Planning Committee (PPC) and maintain them in effect until otherwise revised or amended; in the case of contradictory governing policies and procedures, those policies and procedures from the Commission on HIV – as those incorporated into the Bylaws – will take precedence until such time that those contradictions can be reconciled.	<i>Passed by Consensus</i>	MOTION PASSED
MOTION 3: Approve the Agenda Order for the July 11, 2013 Commission on HIV meeting.	<i>Passed by Consensus</i>	MOTION PASSED
MOTION 4: Continue the FY 2012-2013 Commission operational budget as the governing budgetary authority for the Commission on HIV until such time as the Commission and/or those empowered to act on its behalf in accordance with the Bylaws are able to adjust or revise it consistent with new or different FY 2013-2014 revenue and expenditure projections.	<i>Passed by Consensus</i>	MOTION PASSED
MOTION 5: Establish the regular meeting day and time of the Commission on HIV as the second Thursday of the month from 12:00 noon to 5:00 pm.	<i>Withdrawn</i>	MOTION WITHDRAWN
MOTION 5A: Establish the regular meeting day and time of the Commission on HIV as the second Thursday of the month from 9:00 am to 1:30 pm.	Ayes: Ballesteros, Cadden, Cataldo, Ceja, Enfield, Espinoza, Fox, Garbutt, Giugni, Goddard, Granados, Green, Johnson, Kelly, King, Kochems, Kushner, Land, Lawson, Liso, McMillin, Morales, Palmeros, Pérez, Rios, Rivera, Rotenberg, Samone-Loreca, Sterker, Tran, Tula, Winder Opposed: Gutierrez, Lopez, Rosales, Smith, Zaldivar Abstention: Ortega	MOTION PASSED Ayes: 32 Opposed: 5 Abstentions: 1
MOTION 6: Extend the regular meeting days and times of the Commission's standing committees until such time and if they are shifted to alternate days and/or times by committee votes in consultation with the Executive Committee (<i>Executive Committee: last Monday of the month, 1:00 pm – 3:00 pm; Operations Committee: last Monday of the month, 10:00 am – 12:00 noon; Public Policy (PP) Committee: fourth Wednesday of the month, 1:00 pm – 4:00 pm; Planning, Priorities and Allocations (PP&A): fourth Tuesday of the month, 1:30 – 4:30 pm; Standards and Best Practices (SBP): first Thursday of the month, 10:00 am – 12:00 noon</i>).	<i>Passed by Consensus</i>	MOTION PASSED
MOTION 7: Approve the minutes from the Joint Commission/PPC meetings on May 2, 2013 and June 13, 2013, as presented.	<i>Passed by Consensus</i>	MOTION PASSED

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MOTION AND VOTING SUMMARY

MOTION 8: Approve the remaining minutes from Commission on HIV Executive Committee meetings on October 29, 2012, January 28, 2013 and February 25, 2013, as presented.	<i>Passed by Consensus</i>	MOTION PASSED
MOTION 9: Approve corrections to the FY 2014 Ryan White Part A/B allocations, as presented.	<i>Ayes:</i> Ballesteros, Cadden, Cataldo, Ceja, Enfield, Espinoza, Fox, Giugni, Goddard, Granados, Green, Holloway, Johnson, Kelly, Kochems, Kushner, Land, Liso, Lopez, McMillin, Ortega, Rivera, Rosales, Rotenberg, Samone-Loreca, Scholar, Smith, Sterker, Tula, Zaldivar <i>Opposed:</i> None <i>Abstentions:</i> Garbutt, Gutierrez, King, Lawson, Tran, Winder	MOTION PASSED <i>Ayes:</i> 30 <i>Opposed:</i> 0 <i>Abstentions:</i> 6